STATE OF MICHIGAN

DEPARTMENT OF LABOR AND ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner

In the matter of the Chiropractor
Provider Class Plan Determination
Report pursuant to Public Act 350 of 1980
_____/ No. 05-027-BC

Issued and entered
this 2nd day of August 2005
by Linda A. Watters
Commissioner

ORDER ISSUING DETERMINATION REPORT

I

BACKGROUND

Pursuant to Public Act 350 of 1980, as amended (Act), being MCLA 550.1101 et seq.; MSA 24.660 (101) et seq., the Commissioner of Insurance (Commissioner) issued Order No. 05-003-BC on February 3, 2005, giving notice to Blue Cross and Blue Shield of Michigan (BCBSM), and to each person who requested a copy of such notice, of her intent to make a determination with respect to the chiropractor provider class plan for calendar years 2002 and 2003.

II

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based upon the foregoing considerations it is FOUND and CONCLUDED that:

1. Jurisdiction and authority over this matter are vested in the Commissioner pursuant to the Act.

2. BCBSM has complied with all applicable provisions of the Act.

3. All procedural requirements of the Act have been met.

4. The staff reviewed relevant data pertaining to the chiropractor provider class plan as discussed in the attached report, including written comments received during the input

period on the provider class plan. The input period was designed to provide the public with an opportunity to present data, views, and arguments with respect to the chiropractor provider class plan.

5. Pursuant to Section 510(2) of the Act, a copy of the determination report and this order shall be sent to the health care corporation and each person who has requested a copy of such determination by certified or registered mail.

III

ORDER

Therefore, it is ORDERED that:

1. The attached chiropractor provider class plan determination report shall be incorporated by reference as part of this order and shall serve as the Commissioner's determination with respect to the chiropractor provider class plan for the calendar years 2002 and 2003.

2. Pursuant to Section 510(2) of the Act, the Commissioner shall notify BCBSM and each person who has requested a copy of such determination by certified or registered mail.

3. Pursuant to Section 515(1) and (2), any appeal must be filed within 30 days of the date of this determination report. The request for an appeal shall identify the issue or issues involved and how the person is aggrieved.

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as she shall deem just, necessary and appropriate.

_____

Linda A. Watters
Commissioner

CHIROPRACTOR

PROVIDER CLASS PLAN

DETERMINATION REPORT

for calendar years 2002 and 2003

Office of Financial and Insurance Services

State of Michigan

CHIROPRACTOR

PROVIDER CLASS PLAN

DETERMINATION REPORT

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EXECUTIVE SUMMARY

Pursuant to Public Act 350 of 1980, this report provides a review and determination of whether the arrangements Blue Cross and Blue Shield of Michigan (BCBSM) has established with health care providers have substantially achieved the access, quality of care, and cost goals set forth in the Nonprofit Health Care Corporation Reform Act (Act) for calendar years 2002 and 2003. The statutory goals specify that these arrangements, known as provider class plans, must assure subscribers reasonable access to, and reasonable cost and quality of, health care services covered under BCBSM's certificates.

The analysis and determination of goal performance is based on BCBSM's 2002-2003 chiropractor provider class plan annual report, additional data requested of BCBSM, and information on file with respect to the chiropractor provider class plan. The determination report analyzes the level of achievement for each goal separately and discusses interaction and balance among the goals.

Access Goal

Achievement of the access goal requires BCBSM to be able to assure that, in any given area of the state, a BCBSM member has reasonable access to covered chiropractic services whenever necessary. In analyzing BCBSM's performance on the access goal, consideration was given to the formal and service benefit level participation rates of chiropractors in each geographic region. Given BCBSM was able to maintain formal participation rates of over 86% and an average of 97% on a “per case” basis during 2002 and 2003, it is determined that BCBSM met the access goal for the chiropractor provider class during 2002 and 2003.

Quality of Care Goal

The quality of care goal requires BCBSM to assure that providers meet and abide by reasonable standards of health care quality. To achieve this goal, BCBSM must show that it makes providers aware of practice guidelines and protocols for physician services, that it verifies that providers adhere to such guidelines and that it maintains effective methods of communication with its providers. During calendar years 2002 and 2003, BCBSM required all chiropractors to meet its qualification standards for participation. In addition, BCBSM continued to monitor the effectiveness of provider utilization management and quality assessment programs and maintained communication with chiropractors through its monthly publications, liaison meetings, educational seminars, appeal processes and provider manuals. Therefore, it is determined that BCBSM met the statutory goal for calendar years 2002 and 2003 for the chiropractor provider class.

Cost Goal

The cost goal requires that the arrangements BCBSM maintains with each provider class will assure a rate of change in the total corporation payment per member that is not higher than the compound rate of inflation and real economic growth. Achievement of the cost goal is measured by application of the cost formula specified in the Act, which is estimated

to be 3.1% for the period under review. As the rate of change in the total corporation payment per member for the chiropractor provider class have been calculated to be a decrease of 1.9% over the two years being reviewed, BCBSM met the cost goal stated in the Act for 2002 and 2003.

Overall Balance of Goals

In summary, BCBSM met all three statutory goals for the chiropractor provider class for the two-year period under review.

Determination Report
Order No. 05-027-BC

Introduction

The purpose of this report is to determine whether Blue Cross and Blue Shield of Michigan (BCBSM) met the access, quality of care, and cost goals outlined in the Nonprofit Health Care Corporation Reform Act, MCLA 550.1101 et seq. (Act), with respect to the chiropractor provider class plan for the calendar years 2002-2003.

In addition to the final determination, this report will: define a provider class plan, explain the statutory review process, and provide a detailed summary of the data considered in reaching the determination as well as a statement of findings, which support that determination.

Provider Class Plan - Legal Background

Section 107(7) of the Act, defines a provider class plan as "a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract." Simply stated, a provider class plan is a document that includes measurable objectives for meeting the nonprofit health care corporation's access, quality of care, and cost goals outlined in the Act.

Section 504(1) of the Act requires BCBSM to contract with or enter into a reimbursement arrangement with providers in order to assure subscribers reasonable access to, and reasonable cost and quality of, health care services in accordance with the following goals:

1. BCBSM must contract with or enter into reimbursement arrangements with an appropriate number of providers throughout the state to assure the availability of certificate covered health care services to each subscriber. Section 502(1) of the Act specifically indicates that a participating contract with providers includes not only agreements in which the providers agree to participate with BCBSM for all BCBSM members being rendered care, but also agreements in which the provider agrees to participate only on a per-case basis. Participation with BCBSM means that a provider of health care services agrees to accept BCBSM's approved payment as payment in full for covered services provided to a BCBSM member.

2. BCBSM must establish and providers must meet and abide by reasonable standards of quality for health care services provided to members.

3. BCBSM must compensate providers in accordance with reimbursement arrangements that will assure a rate of change in the total corporation payment

per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

Section 509(4) of the Act requires the Commissioner of the Office of Financial and Insurance Services (Commissioner) to consider various types of information in making a determination with respect to the statutory goals. This information includes:

1. Annual reports filed by BCBSM, which pertain to each respective provider class;

2. Comments received from subscribers, providers, and provider organizations;

3. Health care legislation;

4. Demographic, epidemiological and economic trends;

5. Administrative agency or judicial actions; sudden changes in circumstances; and changes in health care benefits, practices and technology.

The Commissioner shall also assure an overall balance of the goals so that one goal is not focused on independently of the other statutory goals and so that no portion of BCBSM's fair share of reasonable costs to the provider are borne by other health care purchasers. After careful consideration of all of the information that was submitted or obtained for the record, the Commissioner must make one of the following determinations for each provider class plan pursuant to Section 510(1) of the Act:

(a) That the provider class plan achieves the goals of the corporation as provided in Section 504 of the Act.

(b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained and submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to the factors listed in Section 509(4) of the Act.

(c) That the provider class plan does not substantially achieve one or more of the goals of the corporation as provided in Section 504 of the Act.

If the Commissioner determines that the plan does not substantially achieve one or more of the goals, without a finding that such failure was reasonable, BCBSM must transmit to the Commissioner within six months a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the

findings. If after six months or such additional time as provided for in Section 512, BCBSM has failed to submit a revised provider class plan as stated above, the Commissioner must then prepare a provider class plan for that provider class.

Overview of the Chiropractor Provider Class Plan

The chiropractor provider class covers a range of services including spinal chiropractic manipulative treatment, evaluative and management services, radiologic services to diagnose and treat conditions of the spine and contiguous tissues when the condition is due to spinal misalignment or subluxation, emergency treatment of an acute spinal condition, and mechanical traction when performed with chiropractic manipulative treatment.

Prior to 1999, chiropractic benefits included only diagnostic x-rays, manual manipulation of the spine and certain first aid services. Effective March 1, 1999, BCBSM expanded the scope of payable chiropractic services to include some office visits and certain physical therapy modalities. Office services provided on an emergency basis also became payable. These services are subject to the benefit restrictions defined by each subscriber's contract. Many group certificates have limits on the number of chiropractic visits that are payable in a calendar year. Mechanical traction procedures provided by chiropractors are subject to physical therapy limits in the contract. These services are not payable if the contract does not contain physical therapy benefits.

For the period 2002-2003, payments to chiropractors represented an average of 0.9% of the total benefit payments made to health care providers on behalf of BCBSM members. For the purpose of provider class plan reviews by the Office of Financial and Insurance Services (OFIS), paid claims data are categorized by nine geographic regions. A map that depicts these geographic regions is included in Attachment A.

BCBSM's qualification standards in order for chiropractors to participate with and receive reimbursement from BCBSM include only licensure by the state of Michigan, a Michigan practice location, and the signing of a BCBSM *Physician And Professional Provider Participation Agreemen*t.

During the review period, reimbursement to chiropractors was the lesser of the provider's billed charges or the BCBSM maximum payment set forth in BCBSM's Maximum Payment Schedule. The term "billed charge" refers to the actual charge indicated on the claim form submitted by the provider. BCBSM's maximum payment is based on the Centers for Medicare and Medicaid Services resource based relative value system (RBRVS). RBRVS is a schedule of relative procedure values that reflect the resource cost required to perform each service. The resources used in the RBRVS structure include time and work effort, specialty training, professional liability insurance and practice overhead. Values are assigned to each service in relation to the comparative value of all other services.

Multiplying the relative procedure value by a BCBSM conversion factor results in the maximum payment level.

BCBSM states other factors that may be used in setting maximum payment levels include comparison to similar services, corporate medical policy decisions, analysis of historical charge data and geographic anomalies. BCBSM states it may give individual consideration to services involving complex treatment or unusual clinical circumstances in determining a payment that exceeds the maximum payment level. BCBSM may also adjust maximum payment levels based on factors such as site of care or BCBSM payment policy.

During the review period, chiropractors could participate with BCBSM either under its formal participation program or on a per-case basis. A formally participating provider has signed an agreement to accept BCBSM reimbursement as payment in full, excluding applicable co-payments or deductibles, for all covered services rendered to BCBSM members by the provider. Under per-case participation, the provider abides by the terms of formal participation on a case-by-case basis. However, after a provider agrees to participate on a per case basis for a specified procedure, the provider must accept payment from BCBSM as payment in full for that specified procedure for the remainder of the calendar year.

BCBSM is required to include as part of each provider class plan its objectives toward achieving the goals specified in the Act. BCBSM's objectives with regard to the chiropractor provider class plan are as follows:

Access:

- To ensure adequate availability of the high quality medical services, throughout the state, at a reasonable cost to BCBSM subscribers.

- Maintain a reimbursement methodology in conjunction with the Physician and Professional Provider Participation Agreement that is based on the lesser of the billed charges or BCBSM's maximum payment schedule.

- BCBSM will review reimbursement levels at least every 12 months. An alternative reimbursement is available to groups through the Medical Surgical (MS-90) program. The MS-90 program was designed to increase reimbursement levels for purposes of reducing out of pocket payments in regions where participation rates are low.

- Maintain and periodically update the directory of participation physicians and professional providers.

- Maintain and update, as necessary, in the Chiropractor's Manual a "Providers' Bill of Rights" explaining: (1) a provider's right to a managerial level conference under P.A. 350; (2) how the managerial level conference process works and the timeframes involved under it; (3) when the P.A. 350 process can be invoked; and (4) how this process relates to the other processes described in the contract. This communication will emphasize that a managerial level conference is a right guaranteed by law to every provider and that arbitration is an alternative to this right.

Quality of Care:

- To ensure provision of quality care to BCBSM subscribers through the application of participation qualifications and performance standards as a basis for chiropractor participation.

- The Physician and Professional Provider Contract Advisory Committee meets on an ongoing basis, generally at least quarterly, to offer advice and consultation on topics such as: proposed modifications to the contract; administrative issues which may arise under the contract; medical necessity criteria and guidelines; reimbursement issues; experimental or investigational procedures; and, physician supervision of services.

- Work with the Physician and Professional Provider Contract Advisory Committee to review and update medical necessity criteria, as necessary.

- The Chiropractor's Manual is maintained and updated, as necessary, to explain billing, benefits, provider appeals processes, managed care, BCBSM's record keeping requirements and an explanation of the Physician and Professional Provider Participation Agreement and its administration.

- Protocols and procedures relating to the BCBSM's Physician Retrospective Profiling Program are communicated to providers as they become available.

Cost:

- To strive toward limiting the increase in the total chiropractor payments per member to the compound rate of inflation and real economic growth as specified in Public Act 350, giving special consideration to Michigan and national health care market conditions.

- To provide equitable reimbursement to chiropractors in return for high quality services which are medically necessary and delivered to Blue Cross and Blue Shield of Michigan (BCBSM) subscribers at a reasonable cost.

- Each year retrospective profiles are made available to providers upon request.

- BCBSM makes a good faith effort to enforce the per case participation rule in Section 502(1)(b) of P. A. 350 through its audit activities, its provider inquiry and provider consultant activities, and through responses to all complaints. BCBSM will annually report its efforts to enforce the rule and identify any violations that have occurred.

History of the Chiropractor Provider Class Plan

BCBSM had an existing reimbursement arrangement with chiropractors when the Act took effect on August 27, 1985. BCBSM first filed the chiropractor provider class plan with OFIS pursuant to Section 506(1) of the Act on August 31, 1987. Section 506(2) states:

> "Upon receipt of a provider class plan, the commissioner shall examine the plan and shall determine only if the plan contains a reimbursement arrangement and objectives for each goal provided in Section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract."

Section 506(2) further states:

> "For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan."

Since the chiropractor provider class plan met the filing requirements of Section 506 of the Act stated above, OFIS notified BCBSM by letter on September 16, 1987 that the chiropractor provider class plan was placed into effect and retained for the commissioner's records pursuant to Section 506(4).

On November 5, 1987, BCBSM amended all of its provider class plans, including the chiropractor plan, to include an appeal process for utilization review audits performed by the corporation. This amendment to the chiropractor provider class plan was made by BCBSM in accordance with Section 508(1) of the Act.

The chiropractor provider class plan was modified by BCBSM on August 20, 1990, August 2, 1991, February 28, 1995, November 6, 1995, December 30, 1996 and December 22, 2004. The various modifications BCBSM made to the plan included the implementation of a new participation agreement and reimbursement methodology, a revision in the definition

of medical necessity, changes to the participation agreement due to BCBSM's participation in the Inter-plan Teleprocessing System and the disclosure requirements of the Blue Cross Blue Shield Association, a change in the provider appeal process, and updates to the initiatives and objectives of the provider class plan.

The 2004 modifications updated provisions regarding reimbursement, plan objectives, the provider appeals process and covered services. Most of the changes made to the 2004 modified plan merely revise the language used in the previous plan so the terminology used is similar to the terms used in other provider class plans. The only substantive change to the 2004 modified provider class plan is the listing of covered services. The covered services section does not include all services a chiropractor may provide under his or her licensure, but rather specifically lists the services BCBSM will pay for when they are included as benefits in the member's certificate of coverage.

Review Process

On February 3, 2005, the Commissioner issued Order No. 05-003-BC, which provided written notice to BCBSM, health care providers, and other interested parties of her intent to make a determination with respect to the chiropractor provider class plan for the calendar years 2002-2003. Section 505(2) requires the Commissioner to establish and implement procedures whereby any person may offer advice and consultation on the development, modification, implementation, or review of a provider class plan. Thus, Order No. 05-003-BC also called for any person with comments on matters concerning this provider class plan to submit written comments to OFIS in accordance with Section 505(2) of the Act by April 22, 2005.

Summary of Advice and Consultation:

Comments received during the input period on the chiropractor provider class plan were filed on behalf of the Michigan Chiropractic Association (MCA) and the Michigan Chiropractic Society. A response to MCA's and MCS' concerns was filed by BCBSM on June 27, 2005. MCS filed supplemental testimony on July 18, 2005. A summary of the testimony received regarding the chiropractors provider class plan is included as Attachment B.

Discussion of Goals Achievement/Findings and Conclusions

Access Goal:

The access goal in Section 504(1) of the Act states that "[T]here will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

In order to achieve compliance with the access goal, BCBSM needs to be able to assure, that in any given area of the state, a BCBSM member has reasonable access to chiropractic services covered under the terms of that member's certificate of coverage whenever such treatment is required. In analyzing BCBSM's performance on the access goal, OFIS staff examined several aspects of how access to chiropractor services could be obtained, including the formal and service benefit level participation rates of providers, to get an overall picture of how well BCBSM was assuring the availability of certificate-covered health care services to each member throughout the state.

The formal participation rates of chiropractors for calendar years 2002-2003 are presented below.

Formal Participation Rates by Geographic Region

	2003			2002			
Region	**# of Par Providers**	**Total Providers**	**Participation Rate**	**# of Par Providers**	**Total Providers**	**Participation Rate**	**Increase %**
1	758	850	89.2%	709	803	88.3%	1.0%
2	113	134	84.3%	105	127	82.7%	1.9%
3	113	119	95.0%	108	113	95.6%	(0.6)
4	90	98	91.8%	87	98	88.8%	3.4%
5	177	213	83.1%	166	199	83.4%	(0.3)%
6	197	243	81.1%	190	235	80.9%	0.2%
7	101	117	86.3%	98	111	88.3%	(2.3)%
8	119	141	84.4%	114	135	84.4%	0.0%
9	49	66	74.2%	46	65	70.8%	4.8%
Statewide	1,717	1,981	86.7%	1,623	1,886	86.1%	0.7%

The above data demonstrates participation rates have been stable in most all regions, with overall participation rates in the traditional program of nearly 87% in 2003. Both the number of participating providers and the total licensed providers increased over 5% during the two-year period under review. Thus, newly licensed providers clearly are willing to participate with BCBSM.

Another way to assess the availability of chiropractors is by looking at BCBSM's per-case participation rates. BCBSM utilizes "service benefit level rates" as a means to measure financial access because it shows what proportion of certificate covered health services

were made available to members without them incurring any additional out-of-pocket expense other than copays. The phrase "service benefit level rate" refers to the percentage of services paid to providers participating with BCBSM on either a formal or per-case basis who accepted BCBSM payment as payment in full. Analyzing this information is helpful to determine whether the lack of formally participating providers in certain areas truly affects the ability of BCBSM members to obtain chiropractic services. The service benefit level rates for chiropractors for 2002 and 2003 are illustrated below. The data shows that chiropractors generally accepted BCBSM reimbursement, on average, over 97% of the time for services rendered to BCBSM members during the two-year period under review.

Chiropractor
Service Benefit Level Rates

	2003			2002		
Region	**Services Paid In Full**	**Total Services**	**% Paid in Full**	**Services Paid In Full**	**Total Services**	**% Paid in Full**
1	390,370	380,199	97.4%	419.423	409,309	97.6%
2	66,070	63.948	96.8%	74,159	71,476	96.4%
3	78,080	77,029	98.7%	79,617	78,742	98.9%
4	55,258	54,146	98.0%	64,677	63,180	97.7%
5	155,919	152,025	97.5%	156,536	152,351	97.3%
6	175,291	171,265	97.7%	182,161	177,956	97.7%
7	71,176	69,878	98.2%	82,599	81,038	98.1%
8	55,893	54,772	98.0%	69,455	67,056	96.5%
9	19,910	18,675	93.8%	26,603	24,238	91.1%
Statewide	1,067,967	1,041,938	97.6%	1,155,231	1,125,346	97.4%

BCBSM encourages its members to confirm the participation status of a chiropractic provider before they receive services. BCBSM prints provider directories each fall so they are available during the busy fall open enrollment period. Provider directories are updated and printed for the traditional, PPO and POS lines of business. A statewide book and various regional books are printed for each line of business. Chiropractors are included in this directory, along with medical doctors, doctors of osteopathy, psychologists and podiatrists. BCBSM members can also obtain current participating provider information by calling BCBSM's toll-free customer service number or checking BCBSM's website at www.bcbsm.com. BCBSM notes that its website directory is updated on a weekly basis and thus provides a great resource to BCBSM members seeking out physician and professional providers.

The chiropractic associations believe BCBSM has compromised access to care by transferring most of its members to PPO options that are not subject to the provider class plan process. Many of the available PPO options now available to customer groups totally exclude coverage for all services provided by chiropractors even though some services a chiropractor may provide under the scope of his/her license are covered if the service is provided by another type of provider (e.g. physical therapy). Further the chiropractic associations contend BCBSM has disaffiliated a large number of chiropractors from its PPO programs thereby further limiting access to care. MCA believes chiropractors have been disaffiliated from BCBSM's PPO programs at a rate eight times higher than physicians.

As part of the review process, OFIS requested from BCBSM the disaffiliation rates of both physicians and chiropractors from calendar year 2002 to the present. This information is presented in Exhibit A. Both the formal and per claim participation rates for physicians and chiropractors in the traditional program remain stable from year, with slight increases each year for both physicians and chiropractors. Formal participation rates in BCBSM's PPO programs also appear to have remained relatively stable from year to year, with approximately three-quarters of both physicians and chiropractors meeting BCBSM's qualification standards to formally participate in BCBSM's PPO programs.

Section 502a of the Act governs BCBSM's PPO programs. Section 502a(10) states that, "Contracts entered into under this section are not subject to the provisions of sections 504 to 518." BCBSM's PPO programs are therefore specifically excluded from being considered in the review of BCBSM's performance under the provider class plan. However, BCBSM did provide information regarding the number of physicians involuntarily disaffiliated from BCBSM's PPO programs since 2002. This information is provided below:

Provider Type	Number Involuntarily Disaffiliated from PPO				Total Disaffiliations
	2002	2003	2004	2005	
Medical Doctors	6	6	13	5	30
Osteopathic Physicians	6	1	9	1	17
Chiropractors	7	11	49	0	67

This data reveals, in most instances, BCBSM disaffiliated less than one percent of its participating physicians and chiropractors in any given year. While may be true BCBSM disaffiliated twice as many chiropractors than physicians during calendar year 2004, the data does not support MCA's allegations that chiropractors were ousted for over utilization at a rate eight times higher than physicians.

It is important to recognize BCBSM members may seek to receive some of the services chiropractors are eligible to perform under the scope of their licenses from other providers. Members can receive physical therapy services from licensed physical therapists and osteopathic manipulative treatments (similar to chiropractic manipulative treatments) from physicians. Services rendered by these other provider types are reported under their respective provider class plans. It should be noted, however, BCBSM states that members pay the same copay amount for physical therapy services (e.g. mechanical traction) regardless of the type of provider rendering the service. The copay applied to chiropractic and osteopathic manipulation services would likewise be the same. Thus, it does not appear there is any disparity with respect to access to care for these services.

The chiropractic associations have both expressed concern that BCBSM refuses to cover all the services a chiropractor is able to perform under the scope of his/her license and believe BCBSM's failure to cover such services has a negative impact on access to care. Yet nothing in the Act mandates BCBSM provide coverage for chiropractic care at all. BCBSM does not cover every service physicians, dentists, psychologists, or other types of health care providers may provide under their license or every prescription medication available on the market nor should it be expected to do so. That is not to say that chiropractors cannot provide these services and bill their patients for them. BCBSM's customer groups largely decide what services to include in BCBSM's benefit packages.

Ultimately, whether BCBSM covers all the services within the scope of chiropractic practice or not has no relevance to whether or not there are sufficient providers available to provide certificate-covered health care services BCBSM provided to its members during calendar years 2002 and 2003. As such, OFIS recommends the chiropractic associations continue to work with BCBSM at the liaison meetings to come to an agreement as to what chiropractic services BCBSM will cover.

Thus, whether or not BCBSM meets the access goal defined in the Act will be determined by considering whether there is sufficient numbers of chiropractors available to provide the services BCBSM covered under the terms of its certificates of coverage during the two year period under review, rather than whether BCBSM covers all the services a chiropractor is able to perform.

Findings and Conclusions - Access

In order to achieve compliance with the access goal, BCBSM needs to be able to assure that in any given area of the state a member has reasonable access to certificate-covered services, whenever such services are required. Based on the information analyzed during this review, BCBSM was able to maintain formal participation rates of over 86% with chiropractors over the two-year period under review. Further, chiropractors accepted BCBSM payment as payment in full an average of 97% of the time during the same time

period for services rendered to BCBSM members. Therefore it is determined that BCBSM met the access goal stated in the Act for calendar years 2002-2003 for the chiropractor provider class plan.

Quality of Care Goal:

The quality of care goal in Section 504(1) of the Act states that "[P]roviders will meet and abide by reasonable standards of health care quality."

In analyzing BCBSM's performance on the quality of care goal, OFIS staff examined BCBSM's achievement of its quality of care objective, the methods BCBSM utilized in establishing and maintaining appropriate standards of health care quality, and BCBSM's methods of communication with chiropractors. We reviewed these factors to assure BCBSM encouraged provider compliance with the expected standards of chiropractic services. All of the above factors impact the quality of services delivered to BCBSM members. The pertinent issues that were considered in reaching a determination with respect to the quality of care goal, based on the review of data provided by BCBSM and other sources during this review period, are described below.

BCBSM took a threefold approach to achieving its quality of care objectives for the chiropractor provider class. First, BCBSM ensures quality of care by its enforcing its provider qualification and professional standards for participation. Second, BCBSM maintains quality controls such as documentation requirements, provider profiling, and audits. Third, BCBSM strives to forge strong relationships with participating providers by offering various avenues for providers to receive information and to voice concerns regarding benefit coverage and/or claims disputes.

To ensure acceptable levels of care provided by chiropractors, BCBSM requires these providers meet the participation qualifications and performance standards listed on page 3 of this report. BCBSM states chiropractors must be licensed by the state of Michigan and practice in Michigan. BCBSM ensures chiropractor licenses are current through application of an automated licensing verification system that is linked directly to the Bureau of Health Professions in the Michigan Department of Community Health. The Bureau sends an electronic data transfer that is run, at least weekly, against the BCBSM provider database to ensure that BCBSM participating providers retain their licenses to legally practice medicine. BCBSM inactivates the provider identification numbers (PINs) of those chiropractors having had their licenses suspended, revoked or were for other various reasons ineligible to practice chiropractic care to prevent any further claims being paid to these providers. Chiropractors receive written notification from BCBSM that their PINs were deactivated. BCBSM deactivated the PINs of 35 chiropractors during the two-year period under review. Seventeen PINs were deactivated for inactive/invalid licenses in 2002 and 18 PINs were similarly deactivated in 2003. BCBSM states that its Corporate and

Financial Investigations (CFI) department also participates in the provider credentialing process by making recommendations regarding the background and credibility of various participating providers.

BCBSM uses various performance standards to measure how providers rendered health care, taking into account such factors as medical necessity, appropriate utilization and benefit compliance. Routine assurances of quality care were tracked through utilization audits, referral to prepayment utilization review (PPUR) programs, and when necessary, intervention by its CFI department. BCBSM states provider profiling is an important tool it uses to compare provider practices and to identify providers for audit. The primary purpose of profiling is to support appropriate, cost-effective health care services by identifying providers whose practice patterns differ from those of their peers. Practice profiles, which illustrate the comparison of a provider's utilization of key procedures to ones peers, are made available to individual providers who request them. In 2002, 160 chiropractors requested copies of their profiles. In 2003, 69 chiropractors requested a copy of their profiles.

BCBSM performs medical record review audits of to evaluate medical necessity and the quality of care provided to BCBSM members. BCBSM's audit process is not designed simply to recover money, but is BCBSM's way to validate that its contractual agreements were met and high quality care was given to BCBSM members. BCBSM reviews records to ensure compliance with documentation guidelines. BCBSM also compares information in providers' medical and financial records with information reported on claims. Providers are typically selected for review based on data analysis, profiling and comparative reports, prior audit history, and referral from internal and external sources.

The following table summarizes BCBSM's 2002-2003 audit activity for the chiropractor provider class during the two-year period under review.

Year	# of Audits	Referred To CFI	PPUR	Identified Savings	Finalized Recoveries	Pending Recoveries	Audit Cases Appealed to OFIS
2002	6	1	8	$ 321,874	$ 18,750	$ 279,588	8
2003	314	1	7	$ 939,450	$146,580	$ 728,252	19
Total	320	2	NA	$1,261,324	$165,330	$1,007,840	27

BCBSM conducted six audits during calendar year 2002 and 314 during calendar year 2003. All the 2002 audits were field audits. Only seven of the 2003 audits were field audits, with the remaining 307 audits being desk audits conducted to recover payments made in error for more than one office visit billed per year or more than one mechanical

traction service billed per day. BCBSM's claims processing system has been corrected so these inadvertent overpayments are not made in the future.

BCBSM identified initial overpayments totaling over $1.2 million during the two-year period under review. As of December 2004, BCBSM had only recovered only $165,330 of these alleged overpayments, with pending recoveries approximating $1,007,840. Significant findings in these audit cases included:

- Documentation that did not support medical necessity of the service performed
- BCBSM's documentation guidelines were not met.
- Evaluation and management codes billed in excess of benefit limitations
- Over-utilization of x-rays
- Unbundling of x-rays (incorrect coding)
- Emergency visit (CPT 99058) billed for each chiropractor visit or adjustment in order to receive payment for patients who otherwise had no chiropractic benefits

BCBSM disputes MCA's allegation that its utilization management program is noncompliant with the Act. BCBSM states Section 502(3) of the Act authorizes it to refuse to reimburse providers for services that are overutilized.

BCBSM states its liaison committee works with providers to establish utilization standards and policies. When utilization management was discussed at the liaison's September 10, 2002 meeting, all agreed BCBSM and the chiropractic community needed to work together to positively impact utilization. BCBSM ultimately contracted with the American Chiropractic Network (ACN) to act as its consultant in this regard. BCBSM has invited the chiropractors to discuss issues directly with ACN.

BCBSM states it also went to great lengths to communicate its utilization and practice standards to chiropractors for both its traditional and PPO programs. These standards were published in the monthly publication of the *Record*, the chiropractor provider manual and on BCBSM's website. Further, the PPO standards were explained during numerous statewide meetings in 2003. All chiropractors participating in the traditional and PPO programs were individually invited to attend orientation sessions throughout the state to learn about ACN and the many resources it has available for chiropractors to increase their understanding of best practices. Chiropractors were also given a copy of their 2002 ACN profile. ACN provided an explanation of the profiles as these sessions. Additional educational seminars regarding best practices and utilization were also offered statewide to chiropractors during 2003-2004.

Although not a factor in OFIS' determination on the quality of care goal inasmuch as Section 502a(7) of the Act excludes BCBSM's PPO programs from the provider class plan review process, BCBSM states that since ACN became BCBSM's consultant, both parties

have worked with chiropractors whose PPO affiliation statuses were in jeopardy due to utilization standards not being met. ACN and BCBSM have provided chiropractors with corrective action steps to take and other support to help them become compliant with the standards to be able to remain in the PPO network. Those providers not taking advantage of such assistance or failing to take corrective action steps clearly risk being disaffiliated from BCBSM's PPO network.

One measure of BCBSM's achievement of the quality of care goal includes BCBSM's ability to effectively communicate with providers. Given that the quality of care goal defined in the Act requires that "providers meet and abide by reasonable standards of health care quality," it is necessary for providers to be made aware of BCBSM's standards, for BCBSM to verify that its providers adhere to such standards and that BCBSM is responsive to provider inquiries, input, and appeals, as all of these factors impact the quality of chiropractic services given to BCBSM members.

During 2002, BCBSM met with the representatives of the two chiropractic associations. No meetings were held during 2003. BCBSM met with MCS twice during 2004 and once so far in 2005. The MCA has not been invited to more recent liaison meetings due to its pending litigation against BCBSM. BCBSM states meetings and meeting topics overall have been constrained by ongoing litigation. Several discussions were held regarding the content of the updated chiropractic manual and changes were made based upon the input received during the liaison meetings. One meeting held in August 2004 focused on the revisions to the chiropractor provider class plan. BCBSM states some changes were made in the final version of the provider class plan based on its discussions with liaison representatives.

BCBSM states MCS submitted a proposal at the February 15, 2005 meeting to: remove the frequency restrictions on billable evaluation and management (E & M) codes, discontinue BCBSM's current instructions regarding the use of the office emergency services code, remove the "linkage" requirement between mechanical traction and a chiropractic manipulative therapy (CMT) service and add therapeutic exercises, neuromuscular re-education, massage, and therapeutic activities as payable services. MCS proposed all documentation requirements, including documentation of medical necessity, all frequency, bundling and billing limitations that apply to other professional providers, also would apply to chiropractors.

Discussion of this proposal included the acknowledgement that CMT services already include an E & M component related to the condition being treated. E & M services, therefore, would potentially be billed only at the beginning and end of a course of treatment for a specific condition. E & M services could also be billed in situations where a patient sought chiropractic care and a CMT service was not indicated.

BCBSM expressed concern over the use of mechanical traction services, as this service is now being used as an "add on" to nearly every billed CMT service. BCBSM also noted pending Medicare regulations propose to limit payment for physical therapy services to those provided either directly by the physician or by a licensed physical therapist or physical therapy aide. BCBSM has not determined yet as to whether it would adopt these regulations if they become effective, but notes such Medicare changes would likely impact chiropractors' use of physical therapy services, especially massage, on Medicare eligible members.

MCS' representatives stated these services were not simply additional services. The use of these modalities could decrease the need for additional CMT services. It is increasingly recognized that active treatments, based largely on patient directed exercise programs following office instruction and demonstration are essential elements of an effective treatment program.

BCBSM states MCS' proposal is still under discussion through the liaison process. The liaison process is indeed the appropriate forum for changes to be made to chiropractic benefits and coverage. At the present time, BCBSM states it is providing coverage for chiropractic services in accordance with the terms of the 1999 settlement agreement entered into between the parties. Given chiropractic services are not mandated benefits required to be offered by BCBSM, this provider class plan review is not the appropriate forum to address new benefit options for chiropractic services.

During the two-year period under review, BCBSM's Physician and Professional Provider Contract Advisory Committee (PPPCAC) met quarterly in 2002-2003. The PPPCAC was established in 1990 and is actually made up of 2 committees – one for physicians and one for podiatrists, chiropractors and fully licensed psychologists. The PPPCAC podiatrists/chiropractors/fully licensed psychologists committee in 2002 was comprised of three podiatrists, two chiropractors and three fully licensed psychologists. The 2003 provider representation on the PPPCAC included two podiatrists, one podiatric society representative, two chiropractors and three fully licensed psychologists. The chiropractic representatives were the heads of the Michigan Chiropractic Society and the Michigan Chiropractic Association. BCBSM states chiropractic representatives participated in the April and October meetings each year.

BCBSM states the committee played a key role in supporting BCBSM's goal to actively and effectively collaborate with podiatrists, chiropractors and fully licensed psychologists. Topics for discussion during the two-year period under review included BCBSM's cost performance including chiropractors' cost performance, BCBSM initiatives and BCBSM's physician and professional provider fee update evaluation and recommendations.

Review of the minutes from the PPPCAC, however, seem to reveal the committee's function is more to hear about what BCBSM intends to do with policy, reimbursement, etc. rather than advise BCBSM or make recommendations with regard to such proposals. If the non-BCBSM providers actually are asked for input or advice on policy, practice guidelines, benefit changes or reimbursement, it is not reflected in the minutes. The minutes give some credence to MCA's contention the PPPCAC has been an "abysmal failure" in achieving the quality of care goal and objectives as listed in the chiropractor provider class plan. MCA contends BCBSM instead chooses to do most of its negotiating with the chiropractic community at OFIS or the courts.

If advice and consultation is requested from the non-BCBSM chiropractic representatives, future minutes should properly reflect that such advice is requested and what advice is actually provided by PPPCAC members. If advise and consultation is not being requested from the PPPCAC, BCBSM needs to revamp the function of the committee so that it does provide "ongoing support to the physician community" as noted in the provider class plan.

BCBSM states it also maintains open communications with providers through its monthly publications, its formal appeal process and provider manuals. BCBSM consolidated its monthly publications of the *Record, Hospital and Facility News and Service News* in January 2003 into one redesigned monthly newsletter called the *Record.* The consolidation was part of an ongoing effort to improve communications with providers and to make BCBSM information more accessible to them. All participating chiropractors and some non-participating chiropractors receive BCBSM's monthly publications of *The Record*. This publication communicates current information relating to billing, benefit changes, reimbursement and administrative policies. BCBSM's Provider Consulting Services were also available to offer individual, customized information and consultation, building relationships with providers through enhanced visibility, communication and consultative services.

As part of the review process, OFIS examined a copy of BCBSM's provider manual. Formally participating providers receive a comprehensive manual called the *Guide for Chiropractors (Guide).* BCBSM states this manual provides detailed instructions for servicing BCBSM members. In 2000, BCBSM began revisions to the *Guide* to accommodate the recommendations of the MCS and MCA. A CD-ROM of the new *Guide* was mailed to participating providers in July 2004. The *Guide* contains detailed instructions for servicing BCBSM members. Topics detailed in the manual include member eligibility requirements, benefits and exclusions, criteria and guidelines for services, documentation guidelines, reporting procedures, claim submission information, utilization management information, and sections describing how to obtain information from BCBSM's provider inquiry department and claims appeals processes.

It is noted the appeal process outlined in the most current version of the *Guide* contains an incorrect timeframe for the provider to appeal to OFIS. The *Guide* states the provider has only 30 days to request a review and determination from OFIS when the administrative rules governing the review and determination process allow a provider to file a request for a review and determination by OFIS within 120 days of the provider's receipt of BCBSM's findings after the informal managerial conference. BCBSM needs to revise the *Guide* so it appropriately reflects the correct deadline to appeal to OFIS.

The *Guide,* as well as issues of the *Record* and *Physician Update,* is also now available on Web-DENIS, BCBSM's computerized provider inquiry program. Web-DENIS provides information on a patient's contract eligibility coverage, benefits, coordination of benefits, claims tracking and facility claim correction, claims status information and historical eligibility information. CAREN+, an integrated voice response system, is also available to chiropractors to obtain information. CAREN+ provides information on eligibility, benefits, deductibles and copays. BCBSM's automated telephone information system was also available to answer common questions about claim status, overpayment return procedures, supplies, and new provider registration information. Beginning in late 2000, providers were also able to speak directly to a service representative instead of leaving a message. Questions and concerns could also be addressed through written inquiries or addressed by provider consultants located throughout the state.

MCS contends BCBSM has not promptly recognized technological changes now available to the chiropractic community. Chiropractors now use bone density scanners and imaging technology to aid in patient treatment. MCS contends these are covered services when rendered and billed by other provider types, but not when rendered by chiropractors. BCBSM acknowledges certain bone density examinations are payable to medical doctors and doctors of osteopathy, but some of these services are not payable at all. The bone density procedure chiropractors consider to be within their scope of practice is CPT 78350 [bone density (bone mineral content) study, one or more sites: single photon absorptionmetry]. BCBSM states that procedure is not payable by BCBSM to any provider. One of the reasons BCBSM has for its non-payment policy is that it has seen a proliferation of low quality, clinically meaningless testing provided in doctor's offices. Thus, BCBSM has concluded certain tests in certain settings contribute greatly to provider income and very little to patient well-being and consequently, BCBSM sees no rationale for paying for such bone density screenings.

BCBSM maintains a provider appeal process for chiropractors. The purpose of the appeal process is to resolve claim or audit disagreements. BCBSM states that most complaints regarding a BCBSM policy or practice can be resolved through the provider inquiry department or a field service representative. A matter involving medical policy that cannot be resolved through these channels is referred by BCBSM to its medical policy consultants. Providers may also file appeals alleging that BCBSM has violated specific provisions of

Sections 402 and 403 of the Act. Chiropractors are informed of the appeal process through the *Record.* Information about the appeals process is also included in the *Guide* and in the *Physician and Professional Participation Agreement*.

BCBSM's current appeal process, as presented in the chiropractor provider class plan, is described in Attachment C. This appeal process was redesigned in 1994 to be easier, less costly, and quicker to administer while, at the same time, permitting BCBSM to maintain a balance between cost containment and quality care. The appeal process includes a definition of contract issues that can be appealed and, with the establishment of a Physician's Ombudsman office, creates a single focal point within BCBSM for all appeals and disputes. The new process allows providers the additional option of selecting arbitration to deal with non-policy disputes, such as medical necessity determinations. It allows for the costs of arbitration to be shared with a $7,500 cap on provider costs. Non-policy disputes may also been appealed to OFIS or to court. Policy disputes, such as relative value unit assignments, must be settled through the state court system or by OFIS. OFIS received eight requests for review and determinations during calendar year 2002 and 19 requests during calendar year 2003. Of these requests, four cases were settled prior to OFIS determination, one was dismissed and 16 decided by OFIS. The remaining cases were pending at the end of calendar year 2003.

Findings and Conclusions - Quality of Care

In order to meet the quality of care goal, the provider class plan must assure that "providers will meet and abide by reasonable standards of health care quality." During calendar years 2002-2003, BCBSM required all chiropractor providers to meet its qualification standards for participation and continuously monitored their qualification status. BCBSM continued to monitor the effectiveness of provider utilization management and quality assessment programs through its provider profiling and audit processes to ensure providers were conducting business in accordance with their contractual agreements. Lastly, although it does appear BCBSM may need to restructure its PPPCAC meetings to illicit advice and consultation from provider representatives, BCBSM did maintain communication with chiropractors through its liaison meetings, educational seminars, monthly publications, appeal processes and provider manuals. Based on the information analyzed during this review, it is determined that BCBSM met the quality of care goal stated in the Act for the calendar years 2002-2003.

Cost Goal:

The cost goal in Section 504(1) of the Act states that "[P]roviders will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth."

After application of the cost formula found in Section 504 of the Act and using economic statistics published by the U. S. Department of Commerce, it is hereby determined that the measure that will be used to determine BCBSM's achievement of the cost goal shall be as follows:

> The rate of change in the total corporation payment per member for the chiropractor provider class for calendar years 2002-2003 shall not exceed 3.1%.

The pertinent issues that were considered in reaching a determination with respect to the cost goal are described below.

The cost goal formula, as stated in the Act, is

$$\frac{[(100 + I) \times (100 + REG)]}{100} - 100 = \text{Compound rate of inflation and real economic growth}$$

"I" is "inflation" which is the arithmetic average of the percentage change in the implicit price deflator for GNP over the two calendar years immediately preceding the year in which the Commissioner's determination is being made.

"REG" is "real economic growth" which is the arithmetic average of the percentage change in per capita Gross National Product (GNP) in constant dollars over the four calendar years immediately preceding the year in which the Commissioner's determination is being made.

Given the December 2004 population data obtained from population reports published by the U. S. Census Bureau (www.census.gov/popest/national/NA-EST2004.01), and economic statistics for the GNP and implicit GNP price deflator published in the March 2005 edition of "Economic Indicators", prepared for the Joint Economic Committee, by the Council of Economic Advisers (www.gpoaccess.gov/indicators/05marbro.html) the following calculations have been derived:

I = Inflation as defined in the cost goal formula:

	% change in implicit GNP price deflator
2003	1.8
2002	1.7
2 yr. average	1.8

REG = Real Economic Growth as defined in the cost goal formula:

	% change in per capita GNP in constant dollars
2000	2.5
2001	(0.3)
2002	0.9
2003	2.0
4 yr. average	1.3

Using the latest population and economic statistics available, the cost goal for the period under review is estimated to be 3.1%, as shown below:

Inflation = 1.8

Real Economic Growth = 1.3

$$\frac{[(100 + 1.8) \times (100 + 1.3)]}{100} - 100 = 3.1\%$$

Section 517 of the Act requires BCBSM to transmit an annual report to OFIS, which includes data necessary to determine the compliance or noncompliance with the cost and other statutory goals. The report must be in accordance with forms and instructions prescribed by the Commissioner and must include information as necessary to evaluate the considerations of Section 509(4).

As stated in Section 504(2)(e) of the Act, the "'[R]ate of change in the total corporation payment per member to each provider class' means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the commissioner's determination." The cost and membership data for the chiropractor provider class plan for the calendar years 2002-2003, as filed with OFIS by BCBSM, are presented below. Cost data reflect claims incurred in the calendar year and paid through February 28th of the following year.

BCBSM Chiropractor Cost Information	2003	2002	2001	Average Yearly Rate of Change
Total Payments	$33,859,374	$36,655,347	$40,300,405	
Payments/1000 Members	$48,224	$48,294	$50,150	
Rate of Change (%)	(3.7)%	(0.1)%		(1.9)%
Total Services	1,354,780	1,155,231	1,067,967	
Services/1000 Members	1,685.9	1,522.0	1,685.9	
Rate of Change (%)	(0.1)%	(9.7)%		(4.9)%
Payment/Service	$29.75	$31.73	$31.70	
Rate of Change (%)	(0.1)%	6.7%		3.3%
Total Members	803,595	759,000	702,130	

The two-year arithmetic average decrease for the chiropractor provider class plan is 1.9%. This decrease is the result of an average decrease in services per 1000 members of 4.9% and an average increase in the payment per service of 3.3%. BCBSM notes nearly all the decreases in payments and services per 1000 members during the two-year period under review occurred during 2002. Payments and services per 1000 members remained essentially the same in 2003 as 2002.

BCBSM membership in BCBSM traditional products continues to decline as more and more BCBSM customer groups opt for PPO coverage options. Other factors contributing to the membership decline include the corporate downsizing of BCBSM customers and the loss of customer groups to other health care competitors. BCBSM states the number of eligible members using the benefit decreased from 15.3% in 2001 to 13.8% in 2002 to 12.7% in 2003. The number of members utilizing chiropractic services decreased from 104,370 to 89,433 from 2002 to 2003. Both the decreases in the number of total services and percentage of members using chiropractic services contributed to the overall reduction in services per 1000 members of 9.7% in 2002 and 0.1% in 2003. BCBSM states the number of services per patient, however, actually increased during the two-year period under review, from 11 services per patient in 2001 to 11.9 services per patient in 2003.

As shown below, chiropractic manipulative therapy services accounted for the majority of the services billed to BCBSM by chiropractors. Chiropractic manipulative services had a two-year average decrease in utilization of 1.2%. This was the result of an increase of 4.1% in 2003 and a decrease in utilization of 6.4% in 2002. All other chiropractic services saw similar decreases in utilization during the two-year period under review.

Type of Service	Avg Pay/ 1000	Avg Serv/ 1000	Avg Pay/ Serv	3 Year Payments	% of Payments	3 Year Services	% of Services
Manipulative treatment	2.1%	-1.2%	3.4%	$85,500,205	77.2%	2,635,066	73.65%
X-ray services	-11.6%	-11.4%	-0.3%	$12,706,483	11.5%	291,262	8.14%
Mechanical Traction	-14.7%	-14.2%	0.0%	$9,395,536	8.5%	537,960	15.04%
Office Visits	-26.6%	-31.7%	7.5%	$2,281,552	2.1%	56,969	1.59%
All Others	-17.9%	-15.7%	0.3%	$931,350	0.8%	56,721	1.59%
Total	-1.9%	-4.9%	3.3%	$110,815,126	100.0%	3,577,978	100.00%

The chiropractic associations have taken issue with BCBSM's policy that requires a chiropractor to provide manipulative treatment in order for mechanical traction to be a payable service. MCS states the 1999 settlement agreement makes no reference to placing any limitations on the use of mechanical traction. BCBSM states as the 1999 settlement agreement was being finalized its representatives visited chiropractors' offices to determine which physical medicine services should be added as BCBSM covered services. These representatives were shown the traction devices typically used by chiropractors (i.e. spinalator) and were told mechanical traction was really a pre-manipulation service. It was BCBSM's understanding mechanical traction was a way to prepare patients for the manipulation service and that it did not serve any other separate therapeutic value. Thus, based on the input from chiropractors, BCBSM determined mechanical traction provided by chiropractors is only appropriate when spinal manipulation is done at the same encounter.

CPT code 97012, the mechanical traction code billed by chiropractors, is also a procedure code billed by other provider types to treat any part of the body, not just the back. Yet, in 2003, chiropractors accounted for 89% of the payments and 84% of the services billed and paid for by BCBSM. Because CPT code 97012 is a physical therapy code that counts against a BCBSM member's physical therapy benefit maximum, BCBSM is concerned over utilization by chiropractors may exhaust physical therapy benefits a member may ultimately need to treat other types of injuries. Based on the chiropractors' history of utilizing services up to a member's benefit limit, BCBSM feels its requirement that mechanical traction be billed in conjunction with manipulations is a prudent policy to prevent over-utilization.

Section 502(3) of the Act clearly allows BCBSM to apply limitations to benefits in its certificates of coverage. The unlimited use of health care services designed to improve bodily function could cause the cost and use of services to soar and likely cause BCBSM to fail to meet the cost goal for any provider class. The limitations BCBSM has placed on mechanical traction pertaining to the number of times it is payable per day and that it may not be billed unless it is provided in conjunction with a chiropractic manipulation are permissible according to the provisions of Section 502(3) of the Act. The appropriate forum

for chiropractors to seek changes in BCBSM covered services is through the established liaison process as such changes cannot be made by OFIS through the provider class plan review process. Also, if chiropractors believe BCBSM is not living up to the terms of the 1999 settlement agreement between the parties, the chiropractic associations should seek the appropriate legal action to enforce the terms of the agreement.

Further, MCS' concern about including a description of covered services in BCBSM's 2004 modified provider class plan is unfounded. The 2004 modified provider class plan merely reflects BCBSM's current arrangements with chiropractors. BCBSM has, over the years, included a similar listing of covered services in its more recent modified provider class plans. As technology changes and new benefits are offered that are not included in a provider class plan or licensure requirements are changed, BCBSM seeks the necessary provider input and files a modified provider class plan with OFIS to reflect the changes. For example, legislation was passed in 2004 that requires audiologists be licensed. BCBSM has already adjusted its qualification standards in the hearing specialists provider class plan and filed a modified provider class plan with OFIS. This modified provider class plan will take effect as soon as the Department of Community Health completes the steps necessary to adopt administrative rules and begins processing license applications for audiologists. BCBSM can likewise file a modified provider class plan for chiropractors if modifications need to be made upon completion of BCBSM's ongoing discussions with MCS regarding its recent proposal to expand chiropractic benefits.

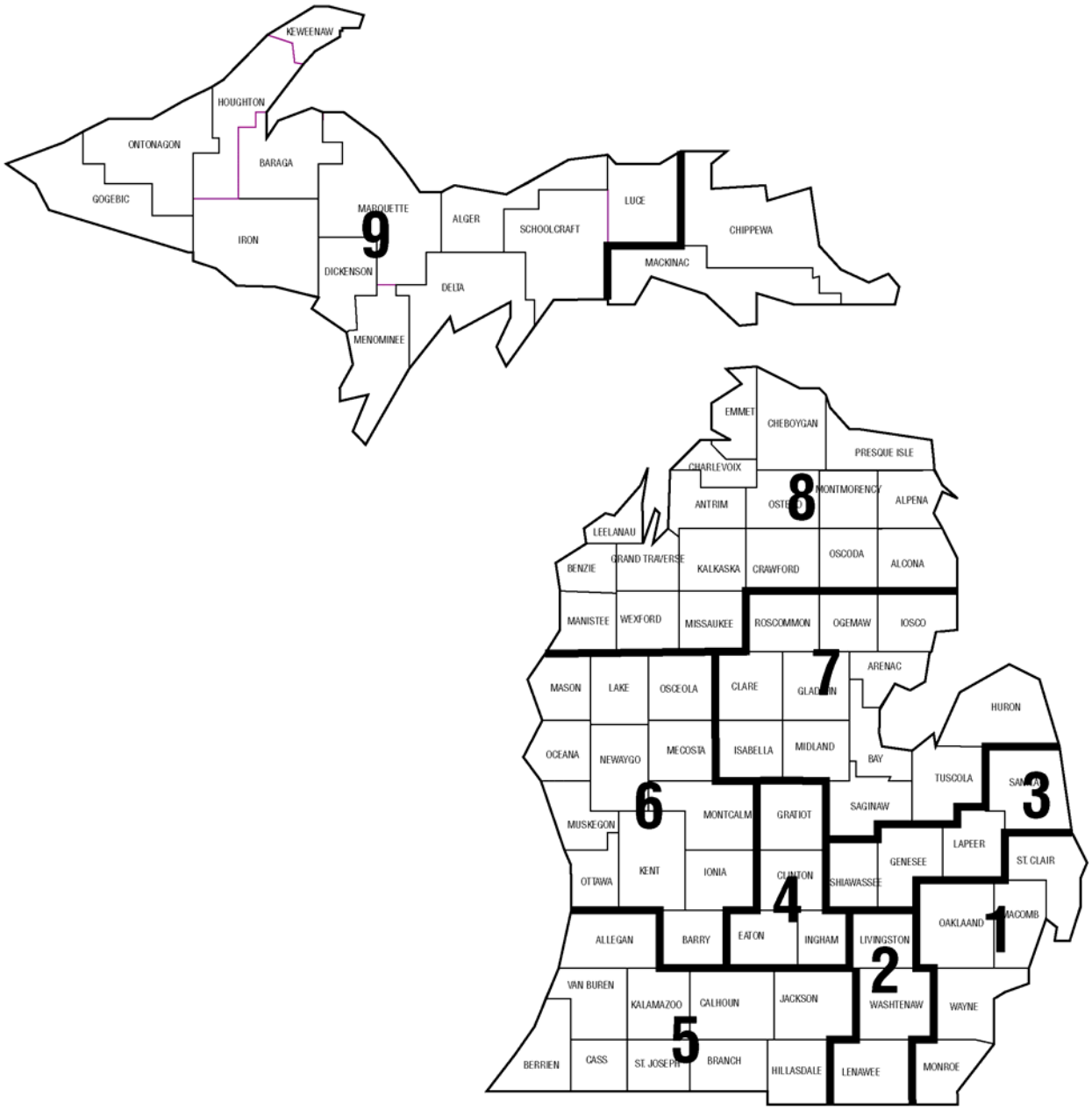
MCS included in its written testimony studies that provide a comparative analysis of individuals with and without chiropractic coverage as well as other studies about the cost effectiveness of physiotherapy and manual therapy for neck pain, chiropractic treatment in workers' compensation patients, the effects of chiropractic care on the Medicare program, and clinical and cost outcomes when using alternative therapies along side conventional medicine. These studies may have been useful to analyze in detail had BCBSM's cost goal performance been deficient as it would have been necessary to conduct a thorough analysis of why BCBSM's payment per member exceeded the compound rate of inflation and real economic growth. The rate of change in the total corporation payment per member for chiropractors during the two-year period under review, however, did not exceed the cost goal specified in Section 504(1) of the Act.

Findings and Conclusions - Cost

Based on the cost information analyzed during this review, it is determined that BCBSM met the cost goal stated in the Act for the chiropractor provider class during the two-year period under review. This decision is based on the fact that the rate of change in the total corporation payment per member for the chiropractor provider class has been calculated to be a decrease of 1.9% over the two years being reviewed, and therefore was below the compound rate of inflation and real economic growth of 3.1%.

Determination Summary

In summary, BCBSM achieved all three of the goals of the corporation during the two-year period under review for the chiropractor provider class.



Attachment A

JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
OFFICE OF FINANCIAL AND INSURANCE SERVICES
DEPARTMENT OF LABOR & ECONOMIC GROWTH
DAVID C. HOLLISTER, DIRECTOR

LINDA A. WATTERS
COMMISSIONER

July 19, 2005

MEMORANDUM

To: File

From: Susan M. Scarane

Re: Summary of Comments Received on Blue Cross Blue Shield of Michigan's Chiropractor Provider Class Plan

The following is a summary of the comments submitted by the Michigan Chiropractic Association (MCA):

MCA takes issue with BCBSM's use of the term "doctors of chiropractic medicine". MCA states Michigan Compiled Laws specifically recognizes members of its profession as "chiropractor", "chiropractic physician" or "D.C.". MCA also states BCBSM has improperly limited a chiropractor's scope of practice in its provider class plan. MCA states chiropractors are licensed and qualified to perform many more services than BCBSM will provide benefits for. Further, MCA takes issue with BCBSM's terminology when referring to spinal subluxations. BCBSM states it covers "radiologic services to diagnose and treat conditions of the spine and contiguous tissues when the condition is due to spinal misalignment or subluxation." MCA believes BCBSM is attempting to alter the intent of Michigan's chiropractic scope statute, which allows doctors of chiropractic to "diagnose and correct subluxations."

MCA sees no reason to require that an adjustment be made by a chiropractor in order to qualify a patient for the benefit of traction. MCA contends no such prohibition is placed on a medical doctor or a physical therapist and illustrates yet another discriminatory policy by BCBSM toward chiropractors that was unilaterally imposed as it was not included in the 1999 settlement agreement between BCBSM and the chiropractic associations.

MCA states it usually must take legal action to get any type of resolution whatsoever as BCBSM refuses to address issues brought forth in its "liaison" process. MCA believes BCBSM is extremely disingenuous when it comes to the

process of conflict resolution. BCBSM has not met with MCA in nearly three years. Further, the PPPCAC has had no impact whatsoever in achieving anything positive as far as chiropractors are concerned. The PPPCAC is an abysmal failure, particularly in light of the fact BCBSM chooses to do most of its negotiating with the chiropractic community at OFIS or in the courtroom.

MCA states BCBSM does not scrutinize providers equally as chiropractors have been singled out and eliminated from BCBSM's PPO programs at eight times the rate of physicians, again illustrating BCBSM's discrimination against chiropractors. BCBSM has never notified providers as to how its physician retrospective profiles are generated, "how they compare to other providers or how other providers' profiles are generated". MCA contends BCBSM has a duty and obligation to notify chiropractors of the standards it expects chiropractors to meet. Further, BCBSM should request input from the chiropractic associations about its utilization management and quality assessment programs before implementing such programs.

MCA states BCBSM's objective to communicate with providers about coverage determinations, billing, benefits, etc. is a noble one. However, MCA believes BCBSM needs to move into the 21st century by publishing such information on an Internet website to provide a single point of dissemination of BCBSM's policies. MCA would also like to see BCBSM's PPO products be subject to the provider class plan review process.

With respect to BCBSM's cost goal objectives, MCA believes BCBSM's financial objectives need to be responsive to the limitations of practice placed Michigan chiropractors by Michigan law, not some unknown "national healthcare market condition[s]". Further, chiropractors should be made aware of the specifics of BCBSM's reimbursement methodologies. MCA does not believe BCBSM's equitable reimbursement objective can be obtained until BCBSM publishes reimbursement methodologies so subscribers and providers can reasonably determine what services will be paid for, rather than subjecting providers to post-payment audits and recoupment.

The following is a summary of the comments submitted by the Michigan Chiropractic Society (MCS):

MCS contends BCBSM's transfer of its business from its traditional program into PPO plans opens the door to the status of its PPO business. More and more of its business ends up in the PPO arena where BCBSM does not underwrite plans but earns significant profits through third party administrator services and lending its name to the creation of provider panels. Assessment of the provider class plan, therefore, must necessarily implicate these other areas, especially when looking at access to chiropractic services.

MCS believes BCBSM violates Section 502(3) of the Act by denying reimbursement to chiropractors for full evaluation and management services, physical medicine, physical therapy and other treatments when it covers such services if performed by other various classes of providers. The current provider class plan is woefully inadequate as it fails to include all the services within the scope of a chiropractor's license as covered services.

MCS states several things need to be looked at during the review process. Access, quality of care and cost goal achievement is affected by whether BCBSM discriminates against chiropractic physicians by not reimbursing them for all the services they can provide under the scope of their license. MCS does not believe a provider class plan can be approved where it fails to recognize as covered services all of the procedures a chiropractor can perform under the scope of his or her license. Another issue is the RBRVS system BCBSM uses to determine reimbursement. BCBSM should not be permitted to deviate from Medicare's resource based relative value system unless there is no relative value for a particular service. The same is true for the conversion factor applied to determine reimbursement for chiropractic physicians. The same conversion factor should be applied to all classes of physicians.

MCS states the demand for chiropractic services is on the rise, yet utilization is being pushed downward. Chiropractors are not being reimbursed for all the services they are licensed to perform. BCBSM has totally failed to take into account the cost effectiveness of chiropractic care as recognized on a national basis. Numerous independent studies have researched and concluded chiropractic care can dramatically reduce overall health care costs. For example, an article published in the October 11, 2004 edition of the *Archives of Internal Medicine* found the cost of treating back pain was reduced by 28% through the use of chiropractic care by reducing the costs spent on back surgery, hospitalization and medical imaging. Another study published in the June 2004 issue of the *Journal of Physiological Therapeutics* found drops of over 58% in hospital days per 1,000, and over 51% in pharmaceutical costs. Even a 2001 Medicare study suggested chiropractic services could play a role in reducing costs of Medicare reform and/or a new prescription drug benefit. Many other published studies made similar findings – that chiropractic care is cost-effective and helps reduce other medical costs associated with back care. MCS contends the provider class plan review must look at the cross over between provider classes to appreciate how chiropractic care contributes to the reduction in the cost of drugs and surgery.

MCS contends BCBSM discriminates against chiropractors by limiting payment of office visits to one per patient, per calendar year. Proper management of a patient may require more than one single evaluative assessment. Most chiropractors will provide such services if it is required for proper patient management. The discrimination by BCBSM, however, will eventually cause less chiropractic physicians to participate with BCBSM, affecting access to care.

In turn, this causes underutilization. This is why it is essential the provider class plan review be done with an eye toward cost savings in other provider classes.

MCS believes the information provided by BCBSM in its annual report regarding access to chiropractic care is misleading. BCBSM claims it has met the access goal because 86% of chiropractors formally participated with BCBSM during the review period. Adding in per-claim participation, BCBSM states its participation rate is 98%. MCS states the disparity between the 86% formal participation and 98% per-claim participation suggests that a large number of chiropractors do not formally participate. Further, patient access is declining as BCBSM membership in the traditional program is transferred into the PPO program.

BCBSM's modified provider class plan filed with OFIS in December 2004 is misleading. It states evaluative and management services are covered as well as mechanical traction when performed with chiropractic manipulative treatment. BCBSM currently only pays for one office visit per year so the plan is misleading because BCBSM indicates evaluative and management services in the plural form. Further, MCS contends there is no legal basis for linking mechanical traction to a chiropractic manipulative treatment. Nowhere in the settlement agreement between BCBSM and the chiropractic associations was there any restriction on the use of traction. It is clear the intent is to reduce access to chiropractors and the full range of services they can provide, particularly given BCBSM's Healthy Blue PPO program prohibits chiropractors from being able to provide physical therapy services to its members.

MCS states BCBSM has not kept up with technological advances by allowing, for example, bone density scanners and imaging technology. MCS claims it is impossible to say BCBSM has met an access goal when it does not allow its members access to the full range of chiropractic services chiropractors are authorized to perform. These services are covered services by BCBSM, but BCBSM simply excludes chiropractors from performing them.

BCBSM's refusal to cover all the services a chiropractor is able to perform under the scope of a chiropractic license impacts both the quality of care and cost of care. The consultant relationship BCBSM has entered into with ACN with respect to its Community Blue/Trust PPO arrangements also has a detrimental effect on access to care as ACN has been attempting to reduce the number of chiropractic adjustments provided to BCBSM members. At the same time, however, ACN has recognized moving a patient into different modalities is one of its goals. Thus, if fewer adjustments are provided, more physical medicine/physical therapy/rehabilitative exercise-oriented techniques may be necessary toward the end of the treatment plan. BCBSM, however, does not pay for these services nor the additional evaluative and management service needed to more promptly remove the patient from active adjustments into self-driven treatment. BCBSM cannot have it both ways. It cannot force adjustment as a method of treatment downward without providing for appropriate alternate care.

Further, it is not appropriate to expect the chiropractic physician to provide these services without pay. What happens then is the patient will forego necessary treatment at the hindering quality of care. BCBSM not only met the cost goal, but also experienced a decrease in both cost and utilization. The dramatic changes that BCBSM is making in its chiropractic care benefits sacrifices quality for cost.

MCS takes issue with BCBSM over its policies on manipulative therapy. Osteopathic physicians bill for such services using CPT codes 98925-98929 and have no limits on the number of visits they may bill. Physical therapists provide manual therapy and manipulation under CPT code 97140 and are allowed to bill a significantly higher number of visits than chiropractic physicians. What this means is the chiropractic physician may be impeded in his/her ability to provide full and complete health care because the patient is limited in the number of chiropractic services s/he can receive. The result is when a patient reaches the visit limit but is still not well; the patient will need to start all over again with another physician whose services will be covered by BCBSM. That physician will have to do an evaluation at the new patient rate, thereby increasing the cost of health care.

Then there is the issue with copays. For most other types of physicians, the copay is charged against the office visit, which is usually a higher amount than a chiropractic adjustment. Only chiropractic care has copays placed upon each and every treatment. For example, a patient may pay a copay for an office visit to an osteopathic physician, but has no copay for an osteopathic manipulative treatment. This discriminatory practice steers patients away from chiropractic care.

Lastly, MCS contends the provider class plan should require procedures for presenting global issues in the future with a set, enforceable mechanism set forth in the provider class plan allowing for provider class issues resolution. The present informal liaison process does not bring about timely resolution forcing providers to litigate issues. Chiropractors basically believe they have done their share to reduce costs and increase effectiveness and quality. It is time for BCBSM to rewrite the provider class plan to eliminate discrimination of the chiropractor provider class.

A response to MCA's and MCS' concerns was filed by BCBSM on June 27, 2005. The following is a summary of BCBSM's response:

BCBSM contends the provider class plan process is not the appropriate forum to raise the chiropractors' complaints about the 1999 settlement agreement or their belief BCBSM has failed to abide by the agreement. Only a court of law has the authority to enforce or vacate a court settlement to which the chiropractors have voluntarily agreed. Discussions to renegotiate the terms of the settlement are underway between BCBSM and MCS. MCA has been invited to join these discussions, but has thus far declined to participate.

BCBSM wishes to emphasize the chiropractors' complaints about BCBSM's PPO programs and Healthy Blue certificates are not subject to the provider class plan review process. These issues have been raised by MCA in its pending lawsuit and will be decided by the court or through the contested care hearing process.

As for MCA's and MCS' complaints about certain wording in the provider class plan, BCBSM agrees that the references to "doctors of chiropractic medicine" are inappropriate. BCBSM agrees the references should be replaced with "doctors of chiropractic" and intends to make this change the next time the provider class plan is revised. BCBSM does not believe complaints regarding the wording of the plan should be considered during the review process. Per Section 509(4) of the Act, OFIS should limit its review to BCBSM's performance under a provider class plan, not the wording of the plan.

BCBSM disagrees that the provider class plan improperly limits the scope of licensure. BCBSM is not legally obligated to cover all the services a provider class is licensed to perform. This if fully recognized in Section 402(1) of the Act, which states that BCBSM "…may limit the health care benefits that it will furnish, except as provided in the act…" and in Section 502(3) of the Act which provides that a member's choice of provider may be limited by benefit limitations in certificates, reimbursement provisions in a provider contract or reimbursement arrangement or to standards set by BCBSM for all contracting providers.

BCBSM notes many Attorney General Opinions interpret these sections, especially Attorney General Opinion 6621 issued on July 13, 1989, as well as the Michigan Court of Appeals in *Cowan v. BCBSM*, 166 Mich App 568 (1988). In Opinion 6621, the Attorney General states on page 181: "This section [Section 502(3)] has been interpreted to mean that while *BCBSM is not required to provide coverage for services unless mandated elsewhere in the Act*, where the certificate does establish coverage for certain health care services, all health professionals licensed to provide those services are entitled to reimbursement."

In *Cowan*, the court agreed and added that Section 502(3) "…evidences a legislative intention to commit the scope of covered therapeutic services to the contracting parties…Where a given medical benefit is not mandated by the statute, its exclusion does not implicate doctor-patient relationship or patient choice concerns cognizable under [PA 350]".

BCBSM claims the chiropractors' argument is not new and has been raised by other provider classes who want BCBSM to cover every service they are licensed to perform. The legislature's intent when enacting licensing laws is to define the scope of licensure, not to mandate coverage for every service that the provider may perform. In fact, more recent licensing laws have included provisions stating the license provisions should not be interpreted as requiring BCBSM or any other carrier to cover all the services within a provider's scope of practice.

With respect to MCA's allegations that the statutory cost goal conflicts with the non-discrimination provisions of the Act, BCBSM states only the legislature may revise the formula as neither BCBSM nor OFIS has the authority to do so.

BCBSM states it has held several liaison meetings with MCA and MCS. Such meetings have been difficult due to the "contentiousness of the MCA's members"; however, BCBSM was able to obtain input on the revised chiropractors' manual. BCBSM also took steps to obtain MCA's input on the 2004 provider class plan even though it ceased meeting with MCA after it filed suit against BCBSM. BCBSM continues to meet with MCS and has done so as recently as May 10, 2005. BCBSM states it discussed whether chiropractor benefits should be expanded during its recent meeting with MCS. MCA has been invited to join in these discussions, but, thus far, has declined to do so.

BCBSM claims it is curious how MCA can make an allegation that the Physician and Professional Provider Contract Advisory Committee is unproductive when its own representatives routinely fail to attend the committee meetings.

The MCA offers no support for its allegation that BCBSM's utilization management is noncompliant with the Act. BCBSM believes its efforts to monitor and manage utilization is authorized by the Act. Section 502(3) authorizes BCBSM to refuse to reimburse providers for services that are over-utilized. Section 3(3) of the Prudent Purchaser Act requires BCBSM to establish selection standards to assure appropriate utilization of health care services. BCBSM is not required to obtain provider input on, or agreement to, the standards to be used to evaluate what is appropriate utilization. Nonetheless, BCBSM has worked with the chiropractors to establish utilization standards and policies through its liaison committee. Utilization management was discussed at the committee's September 10, 2002 meeting. It was agreed the chiropractors and BCBSM's consultant should work together to positively impact utilization. After BCBSM contracted with the American Chiropractic Network (ACN) as its consultant, BCBSM invited the chiropractors to discuss their issues directly with ACN.

BCBSM states it also went to great lengths to communicate its utilization and practice standards, including those pertaining to its PPO programs. Practice standards were published in the *Record*, the chiropractor manual and included on BCBSM's website. PPO utilization standards were explained in numerous statewide meetings held for chiropractors in 2003. Chiropractors were individually invited to attend one of the nine orientation sessions held throughout the state to learn about ACN and the many resources it has available for chiropractors to "increase their understanding of best practices" and to discuss the 2002 ACN individual profile sent to each chiropractor with the invitation. Additional educational seminars were held in 2003-2004 throughout the state. Best practices and utilization were discussed at each seminar. Surveys completed by chiropractors attending these seminars revealed the seminars were informative and helpful.

ACN and BCBSM have worked with chiropractors whose PPO affiliation statuses were in jeopardy because they failed to meet the established utilization standards. The affected chiropractors were provided with corrective action steps to take and other support to help them become complaint with the standards and remain in the PPO network. Chiropractors also have the option of calling the PPO Medical Director, network management staff or an ACN representative to discuss the standards.

BCBSM disagrees with MCA's allegation that it has not explained how chiropractors' profiles are generated, how their profiles compare with peers and how profiles are generated for other providers. These issues have been discussed numerous times in the *Record*. Information on aberrant utilization that can lead to disaffiliation has been published as well. Chiropractors also have 24-hour online access to their ACN profiles. BCBSM believes its efforts to educate and rehabilitate high utilizing chiropractors have gone far beyond what it does for physicians and other providers with high utilization.

As for medical necessity determinations, BCBSM disputes MCA's claim it is not authorized to determine whether a service is medically necessary. Addendum A to the Physician and Professional Provider Participation Agreement that all chiropractors sign states that "for purposes of payment by BCBSM, Medical Necessity or Medically Necessary means a determination by Physicians for BCBSM based upon criteria and guidelines developed by Physicians for BCBSM, or, in the absence of such criteria and guidelines, based upon physician review, in accordance with accepted medical standards and practices, that the service is accepted as necessary and appropriate for the patient's condition…" This definition applies not only to chiropractors but also medical doctors, doctors of osteopathy, podiatrists and fully licensed psychologists.

BCBSM takes issue with MCA's complaint that its objective to meet the cost goal within the confines of "national healthcare market conditions" is patently unfair. The cost goal formula set forth in the Act is based on the compound rate of inflation and real economic growth. These factors are derived from national economic indicators, not local sources. It would not make sense to calculate a cost goal using national data without considering national market conditions. Further, Section 509(4) of the Act makes reference to considering long-term economic trends without regard to whether those trends are local or national. If the legislature had intended only local conditions be considered, it would have specified that only local long-term trends be considered.

With regard to MCA's assertions about reimbursement, BCBSM contends it does provide chiropractors with specifics about its reimbursement methodology – in the provider class plan, the participating contract, the provider manual and on BCBSM's website. Updates about the reimbursement methodology are published in the

Record. Any chiropractor who accesses these sources will be well aware of how reimbursement is determined and what services are covered.

BCBSM cannot understand why MCA would suggest BCBSM have a website where chiropractors can access information about billing, benefits and other topics given BCBSM already has one. BCBSM's current website provides information about benefits, eligibility, how to contact BCBSM and continuing education. More recently, Web Denis, a computerized provider inquiry program, is available online. This program provides chiropractors with information on contract eligibility, benefits, coordination of benefits, claims tracking and claim history.

Whereas the PPO program cannot be considered under a provider class plan review, BCBSM feels compelled to address the PPO issues raised by both MCA and MCS. BCBSM has not used the PPO business to justify low access under the traditional plan. Formal participation under the traditional plan was 87% and the per-claim participation rate was 98%. BCBSM's reference to the shift of membership from the traditional program to the PPO business was merely to explain why membership under the traditional business had decreased. Further, MCS' contention that BCBSM does not underwrite PPO benefit plans is incorrect. BCBSM has many underwritten PPO products, all of which are on file with OFIS.

BCBSM's utilization programs and disaffiliations from the PPO program were in response to a very significant increase in the cost of chiropractic care. From calendar years 1998 to 2003, BCBSM's total payments in Michigan for chiropractic services increased 195% for traditional, PPO and POS products. The increase in the PPO total payment was most significant with a 388% increase in payments. While some of this increase was due to increased PPO membership and an expansion of benefits, a notable portion was due to increased utilization. Moreover, chiropractors experienced the highest percent increase in services per member when ranked with comparable provider specialties (e.g. IPT/OPT, MD/DO, Podiatrists, Psychologists). BCBSM states it contracted with ACN to work with high utilizing PPO chiropractors to help them achieve the best practice of care as both the Act and the PPA Act require BCBSM to contain costs and avoid unnecessary utilization.

BCBSM takes issue with the chiropractors' allegations BCBSM violates Section 502(3) of the Act because it does not reimburse them for the full array of evaluation and management (E & M) codes, physical therapy, physical medicine or other procedures they believe they are licensed to perform given they agreed in the 1999 settlement agreement that they would be reimbursed for only two types of E & M codes, one physical medicine code and x-ray codes. As such, the chiropractors cannot claim BCBSM is discriminating against them by only paying them for those codes. If they wish to expand what they can bill for, BCBSM states the chiropractors should renegotiate the settlement with BCBSM rather than making unfounded claims of discrimination.

BCBSM states the articles submitted by MCS that claim chiropractic care reduces health care costs are deficient in many respects. One study is based on data accumulated over a 19-year period while the others used small data sets. The studies did not always adjust for or take into account the severity of the patient's conditions. Several studies had confounding variables such as health care coverage over time, treatment preferences, cultural stigma or favorable coverage selection. The articles themselves even acknowledge the studies' limitations and the appropriateness of applying the conclusions to larger populations or geographic regions. It is interesting to note four of the six studies submitted were co-authored or sponsored by chiropractors.

BCBSM does not believe the use of chiropractic care can reduce overall health care costs. The payout for chiropractic care increased 195% from 1998 to 2003; with chiropractors experiencing the highest percent increase in services per member when ranked with comparable provider specialties. In addition, chiropractors *routinely* utilize benefits up to a member's benefit maximum (i.e. if a member has coverage for 20 visits, the chiropractor will use all 20 visits). Given this, BCBSM has no reason to believe chiropractic care lowers costs.

Lastly, BCBSM does not believe its benefit design is reviewable under the provider class plan process, as it does not relate to BCBSM's performance under a plan. Sections 402(1) and 502(3) of the Act make it very clear that benefit design is solely within the purview of BCBSM and its customers – not the providers. BCBSM believes this makes perfect sense as BCBSM and its customers bear the cost of health care and are required to ensure members receive quality health care. Thus, BCBSM and its customers should determine what chiropractic care should be covered under benefit plans.

MCS believes BCBSM made several misstatements in its response to OFIS questions and in response to MCA's and MCS' written testimony and thus filed supplemental testimony on July 18, 2005. The following is a summary of MCS' response:

MCS states BCBSM objects to its PPO programs being discussed as part of the provider class plan review, yet tosses out unverified data on PPO payments when it finds it useful. For example, BCBSM cited in its responses to OFIS' questions that it found its PPO payments for CPT 99058 were significantly higher than its traditional payments. Further, BCBSM made reference to its PPO in its 2002-2003 annual report on chiropractors as a reason for the decreases seen in the traditional program as more and more members are shifted into BCBSM's managed care products. BCBSM should not be able to have it both ways – citing PPO information when it is useful, yet objecting to PPO programs being discussed as part of the review of the chiropractor provider class plan. Given BCBSM uses the shift of 52,000 members from the traditional plan to the PPO program as the reason for declining traditional program market share, it strains credulity to suggest PPO information is totally irrelevant to the review process.

BCBSM also made a reference to MCS' failure to list CPT 99058 on the list of services chiropractors consider within the scope of chiropractic. BCBSM's reply to OFIS' questions were made long after a February 15, 2005 liaison meeting where the two parties agreed to discontinue the use of the current instructions regarding the use of the office emergency services code.

MCS claims BCBSM attempts to divert attention from the central issues by arguing the chiropractors' issues really relate to the 1999 settlement agreement, BCBSM's PPO programs, its customers' benefit plans and other issues unrelated to the provider class plan. Yet, never before has BCBSM attempted to delineate what the "covered services" were within the provider class plan. BCBSM may not hide from its obligation to pay for covered services by delineating an improperly restrictive set of services in its proposed plan and then object to chiropractic arguments by claiming these are either matters settled by the 1999 agreement or are matters of covered benefits.

MCS notes BCBSM, when submitting a list of procedure codes within the scope of chiropractic, states, "it does not necessarily agree" with the codes. By including the listing, BCBSM acknowledges it fails to pay for CPT codes 99241-99243, CPT codes 99271-99273, CPT codes 99371-99372 and physical medicine and rehabilitation services as well as CPT 95831-95851. MCS contends BCBSM's response shows it fails to recognize the full scope of chiropractic.

MCS claims BCBSM wants OFIS to review the provider class plan in reverse. BCBSM argues there is no basis for putting scope issues in a provider class plan if BCBSM does not provide them as benefits. The provider class plan is the document from which all else flows. As new coverage plans are issued by BCBSM, if cannot possibly address reimbursement arrangements for other benefits if the provider class plan restricts a provider class to something less than its full scope of authority.

MCS is astonished by BCBSM's explanation as to why it requires a chiropractor do an adjustment in order for mechanical traction to be payable. The 1999 settlement agreement makes absolutely no such restriction. BCBSM made this restriction without regard to scope of chiropractic practice based on some unspecified study it conducted and then etched this restriction into the 2004 modified provider class plan. Is osteopathic manipulative therapy linked to traction in such fashion? MCS finds BCBSM's concern that a traction code might be abused by chiropractors offensive.

MCS contends BCBSM's response raises the real issue at hand - the scope of chiropractic. To suggest proper access and quality considerations may be divorced from the scope of practice is to simply suggest OFIS should allow BCBSM to determine on its own what appropriate conduct is. Proper access and quality cannot be determined unless the scope is a part of the inquiry.
MCS contends the most incredibly disingenuous position BCBSM advances is the suggestion the 1999 settlement agreement took care of all reimbursement issues. It

defies logic that the parties would agree in 1999 to foreclose any potential future reimbursement beyond what was in the agreement. In fact the agreement clearly states the settlement is not to be interpreted by BCBSM as a waiver or limitation by the chiropractic associations as to the scope of chiropractic or on reimbursement for services provided other than under the agreement.

The agreement recognizes additional trauma may occur to an established patient for which a single evaluative and management visit during a calendar year may not be sufficient. CPT code 99058 was to be used to address this situation. The parties agreed to work together to further develop the appropriate criteria for emergency visits. BCBSM knew the clear intention of the settlement provisions was to address the issue of additional payable evaluative and management visits. Secondly, the settlement agreement does not include any restrictions whatsoever on the use of mechanical traction. Clearly, BCBSM has failed to abide by the terms of the settlement agreement by placing restrictions on "covered services". MCS contends BCBSM may not limit the provider class plan description of covered services to something less than the full scope of authority.

MCS takes issue with BCBSM's statements that the provider class plan review process is limited and not the appropriate forum to challenge the 1999 settlement agreement or BCBSM's reimbursement methodology. BCBSM forgets it is also seeking to file a modified provider class plan. Thus, BCBSM's view of the current proceeding is overly circumscribed. A modified provider class plan looks to the future. No plan can be adopted that fails to recognize the scope of practice of the provider class plan at issue.

MCS contends since BCBSM has not conducted or prepared any studies to address the efficacy of chiropractic care, the studies presented by MCS must be accepted as establishing that chiropractic care is under utilized by BCBSM and therefore, access is inappropriately low. BCBSM must further be required to keep the conversion factors among classes of physicians equal and to utilize the RBRVS system.

Lastly, MCS takes issue with the "utilization driver" chart BCBSM submitted to substantiate that chiropractic physicians have "the highest percent increase in services per member when ranked with comparable provider specialties." The chart submitted included data from 1998-2002. Including 1998 data would undoubtedly increase chiropractic utilization as evaluative and management services and mechanical traction services did not become payable to chiropractors until March 1, 1999. MCS contends to include pre-settlement discriminatory numbers to create a baseline "bootstraps unlawful conduct into the data" and includes data falling outside the review period.

ATTACHMENT C

BLUE CROSS BLUE SHIELD OF MICHIGAN
PROVIDER APPEAL MECHANISMS
PERTAINING TO THE
CHIROPRACTOR PROVIDER CLASS

BCBSM's appeals process includes three potential forums for dispute resolution and is intended to resolve disputed matters quickly and inexpensively. Steps 1 and 2 of the appeal process satisfy the administrative procedure outlined in the Act. Please note that an election must be made at the conclusion of Step 2 regarding binding arbitration, OFIS review or judicial review of the dispute. Once the provider elects one of these three methods for final resolution of the dispute, the remaining two remedies and procedures are deemed waived for that particular dispute. The provider has the right to appoint another person to act as his/her agent or representative in any of the steps of an appeal.

Disputes may be appealed to OFIS or court action may be initiated. Binding arbitration is available for some types of disputes. Non-policy disputes may be arbitrated. Non-policy issues include by way of example: a) medical necessity determinations; b) claims denials under the pre-existing condition exclusion in member's agreements; and, c) audit recovery demands involving requests for repayment of monies related to services unsupported by the documented medical record.

The arbitration option is not available for policy related disputes. Policy related issues include by way of example: a) RVU assignments or conversion factors, both of which affect BCBSM's price per procedure; b) experimental or investigational benefit exclusions; c) departicipation decisions; and, d) audit methodologies, such as the use of statistical sampling for audit refund projections.

APPEAL PROCESS STEPS

After the provider has completed BCBSM's normal status inquiry, telephone and written inquiry procedures, the provider shall begin the appeals process by submitting a written complaint to BCBSM regarding the nature of any unresolved areas of the dispute. BCBSM shall, within 30 days, provide in writing a clear, concise and specific explanation of all of the reasons for its action that addresses the provider's complaint.

If the provider does not agree with BCBSM's explanation, the provider may request a managerial-level conference within 60 days of receipt of BCBSM's written explanation. The notice should be sent to BCBSM's Conference Coordination Unit. BCBSM will schedule the informal conference within 30 days of receipt of the provider's request. At the request of the provider, the conference may be held by telephone. The purpose of the informal conference is to discuss the dispute in an informal setting and explore possible resolution of that dispute. If the dispute involves matters of a medical nature, a BCBSM consulting provider will participate in the conference. If the dispute is non-medical in nature, other appropriate BCBSM employee(s) will attend.

Within 10 days following the conclusion of the informal conference, BCBSM shall provide all of the following to the provider: a) the proposed resolution; b) the facts, with supporting documentation, on which the proposed resolution is based; c) the specific section or sections of the Act, certificate, contract or other written policy or document on which the proposed resolution is based; (d) a statement explaining the provider's right to appeal the matter within 30 days after receipt of BCBSM's written statement; and, (e) a statement describing the status of each claim involved.

Within 30 days after receipt of BCBSM's post conference findings, the provider shall have the right to appeal BCBSM's proposed resolution either by submitting a Demand for Arbitration to BCBSM or by submitting a request to OFIS for a review and determination. The provider shall also have the option of initiating litigation in the appropriate court. The provider's election to pursue binding arbitration is a waiver of any and all other remedies or procedures for resolution of the dispute. Similarly, notice of the provider's election to request that OFIS conduct a review and determination or the election to litigate the dispute waives any right to submit the dispute to binding arbitration.

Binding arbitration of the provider's dispute is an alternative to judicial review in any appropriate court of law or to an administrative review by OFIS under Part 4 of the Act. Requests for arbitration should be sent to BCBSM's Doctor Arbitration Department. A judgment of any circuit court may be rendered upon an arbitration award made in this type of dispute.

Alternatively, the provider may elect to have the dispute reviewed by OFIS under Part 4 of the Act. The provider may initiate an informal review and determination of the dispute by submitting a written complaint to OFIS within 120 days of receipt of BCBSM's determination and should specify which provisions of Sections 402(1) and 403 of the Act that BCBSM has violated. The informal review and determination may take place through submission of written position papers or through the scheduling of an informal meeting at the offices of OFIS. OFIS shall issue its determination in a timely manner after its receipt of position papers requested of the parties.

If dissatisfied with the review and determination by OFIS, either the provider or BCBSM may ask the Commissioner to hear the matter as a contested case under the Michigan Administrative Procedures Act. A contested case must be requested in writing within 60 days after the review and determination is issued. Either the provider or BCBSM may appeal the contested case result to the Ingham County Circuit Court.

Formal Participation Rates
Traditional Progarm

Provider Type	2002			2003			2004			2005 (to date)		
	Total Prov	# Part.	Par Rate	Total Prov	# Part.	Par Rate	Total Prov	# Part.	Par Rate	Total Prov	# Part.	Par Rate
M.D./D.O.	21,785	20,744	95.2%	22,268	21,309	95.7%	23,198	22,250	95.9%	23,417	22,598	96.5%
Chiropractors	1,824	1,555	85.3%	1,886	1,623	86.1%	1,981	1,717	86.7%	2,012	1,767	87.8%

Per Claim Participation Rates
Traditional Progarm

Provider Type	2002			2003			2004			2005 (to date)		
	Total Services	Total Serv Paid in Full	Per Claim Par Rate	Total Services	Total Serv Paid in Full	Per Claim Par Rate	Total Services	Total Serv Paid in Full	Per Claim Par Rate	Total Services	Total Serv Paid in Full	Per Claim Par Rate
M.D./D.O.	9,073,938	8,759,984	96.5%	8,243,218	8,047,684	97.6%	6,891,776	6,761,548	98.1%	NA	NA	NA
Chiropractors	1,155,231	1,125,346	97.4%	1,067,967	1,041,938	97.6%	902,306	888,528	98.5%	NA	NA	NA

Formal Participation Rates
PPO Progarm

Provider Type	2002			2003			2004			2005 (to date)		
	Total Prov	# Part.	Par Rate	Total Prov	# Part.	Par Rate	Total Prov	# Part.	Par Rate	Total Prov	# Part.	Par Rate
M.D./D.O.	21,785	15,468	74.6%	22,268	16,257	76.3%	23,198	17,228	77.4%	23,417	17,874	79.1%
Chiropractors	1,824	1,367	75.0%	1,886	1,410	74.8%	1,981	1,513	76.4%	2,012	1,512	75.2%